STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE TENNESSEE
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT
RATES FOR INPATIENT HOSPITAL SERVICES

REIMBURSEMENT METHODOLOGY FOR PROVIDERS OF ACUTE CARE HOSPITAL SERVICES

All hospitals enrolled in the Tennessee Medicaid Program, except those specified as exempt, with fiscal years beginning on or after October 1, 1983, shall be reimbursed on a prospective payment methodology. Exempt providers, shall be reimbursed in accordance with Medicare, Title XVIII principles and standards in effect on October 1, 1982, and described in 42 CFR 405. Exempt providers are subject to the revaluation of assets provision, Section 2314 of the Deficit Reduction Act (DEFRA). Enrolled hospitals shall meet state licensure requirements for an acute care hospital and shall be certified by the Medicare program as an acute care hospital as of the date of the hospital's enrollment in the Tennessee Medicaid Program.

Cost Reporting Requirement - In order to be eligible for payment by the Medicaid program for hospital services provided to Tennessee Medicaid beneficiaries, providers, including those paid by a prospective method, are required at each provider's fiscal year end, upon termination of provider status, change in ownership, or enrollment as a new provider, to submit to the Comptroller of the Treasury an annual cost report on forms designated by the Department. This report shall be submitted not later than three months from the end of each provider's fiscal year. Such cost reports must be completed in accordance with the Medicare principles of cost reimbursement set out in the Medicare Provider Reimbursement Manual, in effect on October 1, 1982, except where the Department may specify otherwise. All covered services are to be in accordance with the Medicaid Program definition of covered services.

Providers which fail to submit cost reports which comply with Title XVIII principles in effect on October 1, 1982 and described at 42 CFR 405 shall be subject to penalties imposed by such regulations. Except as stated in Providers Exempted from Prospective Payment Methodology, hospitals not filing cost reports for a specific period shall be required to refund all payment made under this program for that period.

Any contracting provider that does not adopt the uniform classification of accounts, or other acceptable accounting methods as shall be established by the Department of Health in consultation with the Comptroller and the Tennessee Hospital Association, or does not submit cost data as required by the Department of Health, shall be assessed a penalty of ten dollars ($10.00) for each day such provider is not in compliance.

Records Retention - Each hospital provider is required to maintain adequate financial and statistical records which are accurate and in sufficient detail to substantiate the cost data reported. These records must be retained for a period of not less than five years from the date of the submission of the cost report, and the provider is required to make such records available upon demand to representatives of the State Department of Health or the United States Department of Health and Human Services. All cost reports shall be retained by the State Comptroller of the Treasury for a period of not less than five years from the date of submission of the cost report.

Audit Requirements - All hospital cost reports are subject to audit at any time by the Comptroller of the Treasury and the Medicaid Agency or their designated representative. Cost report data must be based on and traceable to the provider's financial and statistical records and must be adequate, accurate, and in sufficient detail to support payment made for services rendered to beneficiaries. Retroactive adjustments to the prospective rate may be made for audit exceptions. Hospitals will be subject to medical audits at any time. Medical audits include, but are not limited to, "medical necessity" or "length of stay." Medical audit exceptions may result in a direct recoupment rather than in a rate change.

Providers Exempted From Prospective Payment Methodology - (A) Long-term care facilities (hospitals that have an average length of stay of more than 25 days). (B) Hospitals that elect not to submit a cost report and which have less than $100,000 annually, based on the State of Tennessee's fiscal year, in total charges to patients determined eligible for Medicaid by the State of Tennessee; the annual total charges do not include charges associated with transplants covered by Tennessee Medicaid and are reimbursed as specified in Section 1-Prospective Payment Methodology.

Such providers shall be reimbursed an amount not to exceed 80% of reasonable charges for covered items billed by the provider. Reasonable charges are those which are charged by comparable providers for similar services. In the event that providers exceed $100,000 in total Tennessee Medicaid charges annually:

(a) In-state hospitals or out-of-state hospitals in contiguous medical marketing areas, will be treated as new providers as specified in Section 1-Prospective Payment Methodology.

(b) All other hospitals will be exempt from the prospective payment methodology and are reimbursed as specified in Section 2-Method for Paying Providers which are Exempt from Prospective Payment Methodology.

1. Prospective Payment Methodology

A. Effective October 1, 1983, the prospective payment will be made as a rate per inpatient day. Each facility's reimbursable inpatient costs will be determined in accordance with Title XVIII form a base year cost reporting period. Costs will be separated into an operating component and a pass-through component. A trending factor will be applied to the operating rate component only. The prospective rate will be the sum of the trended operating component and the untrended pass-through component, plus or minus adjustments for minimum occupancy (effective October 1, 1989 Tennessee Medicaid will not impose a minimum occupancy penalty), resident and intern costs, Medicaid disproportionate share, and other adjustments. Where appropriate, Tennessee Medicaid costs will be determined either by a computed utilization ratio from form HCFA- 2552 81(11-81) or, at the option of the provider, from form HCFA- 1007 which must be submitted by the provider.

B. Beginning July 1, 1987 the prospective payment will be made as a rate per inpatient day for the operating component and a quarterly lump-sum payment for the pass-through, disproportionate share, and indirect education adjustment.

Beginning January 1, 1988 the prospective payment will be made as a rate per inpatient day for the operating component and a monthly lump-sum payment for the pass-through, disproportionate share, and indirect education adjustment.

Beginning July 1, 1989, except for inpatient hospital days involving approved organ transplants, the first twenty (20) days per fiscal year will be reimbursed at 100 percent of the operating component plus 100 percent of the capital, direct and indirect education, return on equity (for proprietary providers only), and Medicaid disproportionate share adjustment (MDSA) components. For medically necessary days in excess of twenty (20) per fiscal year, reimbursement will be made at 60 percent of the operating component plus 100 percent of the capital, direct and indirect education, return on equity (for proprietary providers only) and MDSA components. Approved inpatient days involving organ transplants will be reimbursed at 100 percent of the operating component plus 100 percent of the capital, direct and indirect education, return on equity (for proprictary providers only) and MDSA components. Admission and stays involving organ transplants that span fiscal years will be reimbursed as if the entire stay had occurred during the first fiscal year.

C. Adjustments to Base Period Costs - It may be necessary to adjust base year cost reports to make the base period costs comparable to inpatient costs incurred in the prospective period, such as costs to be incurred by hospitals required to enter the Social Security system beginning January 1, 1984. Therefore, hospitals submitting form HCFA-1008 to their Medicare intermediary should send a copy of this form to the Comptroller of the Treasury. For hospitals which do not submit form HCFA-1008, appropriate adjustments will be made based on the best available information.

D. Pass Through Component

(1) Each facility's initial prospective rate will be based on a base year cost report and will include a pass-through component consisting of the portion of capital costs, medical education costs, and return on equity (for proprietary providers only) which is attributable to patients determined eligible for Medicaid by the State of Tennessee. The pass through component may vary from year to year depending on each facility's actual capital costs, medical education costs, and return on equity and will not be computed until the facility's cost report is received.

2(a) Effective October 1, 1991 and later, capital related costs will be reduced by 15% for dates of service October 1, 1991 and later. Reduction will be figured into year end final settlements. Hospitals designated as Sole Community Hospitals are exempt from percentage reductions in capital related costs.

(b) Additional capital costs due to revalued assets will be recognized only when an existing provider is purchased by another provider in a bona fide sale (arms length transaction). The new value for reimbursement purposes shall be the lesser of (1) the purchase price of the asset at the time of the sale, (2) the fair market value of the asset at the time of the sale (as determined by an MAI appraisal), (3) current reproduction cost of the asset depreciated on a straight line basis over its useful life to the time of the sale, or (4) for facilities undergoing a change of ownership on or after July 18, 1984, the acquisition cost to the first owner on record on or after July 18, 1984. The cost basis of depreciable assets in a sale not considered bona fide is additionally limited to (5) the seller's cost basis less accumulated depreciation. The purchaser has the burden of proving that the transaction is a bona fide sale should the issue arise. Gains realized from the disposal of depreciable assets while a provider is participating in the program are to be a deduction from allowable capital costs. All sales as of July 18, 1984, will be in compliance with the provisions of Section 2314 of DEFRA.

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(3) The payment of return on equity will be determined by Medicare principles of cost reimbursement, 42 CFR 405, in effect on August 1, 1983 providing that, effective April 20, 1983, return on equity shall be adjusted to reflect 100% of the average rate of interest on obligations issued for purchase by the Federal Hospital Insurance Trust Fund.

EXAMPLE

Base year:	12/31/82
Base Year Cost Report Received	05/01/83
Initial Prospective Rate Determined	06/01/83
Beginning of Prospective Payment	01/01/84
12/31/83 Cost Report Received	05/01/84
12/31/83 Cost Report Rate Adjustment Completed	06/01/84

In this example, the initial prospective rate continues until June 1, 1984. On June 1, 1984, the rate is adjusted (for service dates on or after June 1, 1984) for the Tennessee Medicaid share of the actual capital costs, medical education costs, hospital-based physician costs, and return on equity (for proprietary providers only) reported on the December 31, 1983, cost report.

(4) Beginning July 1, 1987 the pass-through component will be paid as a quarterly lump-sum payment established in June of each year. The quarterly payment will be prospective based upon the most recent cost report with adjustment for all audited cost.

Example

First year
Pass through cost based on an unaudited cost report for year-end June 30, 1986. $200,000

Second year
Pass through cost based on an unaudited cost report for year-end June 30, 1987. $240,000

Third year
Pass through cost based on an unaudited cost report for year-end June 30, 1988. $260,000
Final audit cost for July 1, 1987 through June 30, 1988. $180,000

*7/1/87 through 6/3/88 payment	-200,000
less audit cost 7/1/87 thru 6/30/88	+180,000
Adjustment to current year	-20,000
Current year payment	
Based on last unaudited report	+260,000

(5) Beginning January 1, 1988 the pass-through component will be paid as a monthly lump-sum payment established in June of each year. The monthly payment will be prospective based upon the most recent cost report with adjustment for all audited costs.

E. Operating Component - Each facility's initial prospective rate shall also include an operating component which is based on the base year cost report. The operating component will be trended forward each year. The trending index which shall be used to arrive at the operating component in the initial prospective year shall be the estimated actual rate of increase in Medicare inpatient operating costs which is in effect during the trending period and which is furnished by the Health Care Financing Administration's Office of the Actuary. The trending period shall be from the midpoint of the hospital's base year to the midpoint of the hospital's first cost reporting period subject to prospective payment. Except for trending to the new rebased year (1988 cost reports or if not available the prior cost report) which will be the indexing rate recommended by the Prospective Payment Assessment Commission, the trending index which shall be applied to operating component shall be as follows:

Period Covered	Rate
10/1/85-9/30/86	0%
10/1/86-9/30/87	1.15%
10/1/87-6/30/88	2.7%
7/1/88-6/30/89	0%

Thereafter, the trending index shall be that rate of increase on prospective payments as recommended by the Prospective Payment Assessment Commission and as published in the Tennessee Administrative Register. The trending indexes above shall be applied from the midpoint of each provider's fiscal year, to the midpoint of the subsequent fiscal year. When necessary, indexes will be prorated to correspond to a provider's year end. Each provider will be notified of its new operating rate due to indexing within 30 days of the beginning of each fiscal year.

Example: Provider X has a 9/30/86 fiscal year end. Indexing midpoint to midpoint would be from 4/1/86 to 3/31/87. The appropriate index is .575 computed as follows:

(0% x 6/12) + (1.15% x 6/12) = .575

F. Minimum Occupancy Adjustment - Capital costs shall be adjusted each year, using the formula set out below, if a facility's occupancy rate, based on staffed beds during the year, is below a minimum level. If a hospital exceeds its minimum occupancy rate, the formula is not applied. The minimum level is as follows:

Hospitals over 100 beds - 70%
Hospitals with 100 beds or fewer - 60%

The adjustment will be computed as follows and will be made at the same time as the pass through adjustment.

$$ACC = TCC \times \frac{TBD}{ABD(Y)}$$

ACC = allowable capital costs
TCC = total capital costs
TBD = total bed days used during the period
ABD = total bed days available during the period
Y = .6 for hospitals with 100 beds or fewer
.7 for hospitals over 100 beds

All references to beds means staffed beds. Staffed beds mean those beds which are equipped and available for patient use. Any beds or hospital wing which is unavailable for patient use such as being closed for reasons including but not limited to, painting, maintenance, or insufficient nursing staff will not be considered staffed beds. It shall be the responsibility of the provider to determine at least monthly, its number of staffed beds. A schedule showing the number of staffed and unstaffed beds, along with the reasons for being unstaffed, must be submitted with the cost report. This schedule is subject to audit. If no schedule of staffed beds is received, staffed beds will be the number of beds at the end of the cost report period. Effective October 1, 1989 Tennessee Medicaid will not impose a minimum occupancy penalty.

G. Resident and Intern Cost Adjustment - (1) On the basis of the ratio of full time equivalent residents and interns to total beds, a resident and intern cost adjustment shall be granted to teaching facilities having an approved residency program. Such facilities will be given this adjustment independent of the Medicaid disproportionate share adjustment. The resident and intern cost adjustment shall not be subject to trending. The cost adjustment shall be calculated using the following formula but shall not exceed 10%, and will be made at the same time as the pass through adjustment.

$$RI = 1.89 \times \left[\left(1 + \frac{\text{interns and residents}}{\text{beds}}\right)^{.405} - 1 \right]$$

(2) For purposes of this adjustment, hospitals are to report only full-time equivalent interns and residents on form HCFA 1008, Part 1. For years when form 1008 is no longer in effect, hospitals must submit their number of full-time equivalent interns and residents with their cost report. The number of full-time equivalent interns and residents is the sum of : (a) interns and residents employed 35 hours or more per week, and (b) one-half of the total number of interns and residents working less than 35 hours per week regardless of the number of hours worked.

EXAMPLE - assuming no Medicaid Disproportinate Share minimum occupancy adjustment for October 1, 1983 thru June 30, 1987.

		Year 1	Year 2	Year 3
1.	Operating Component Prior to Trending	$250.00	$277.50	$299.70
2.	Pass Through Component	25.00	30.00	35.00
3.	Basis for RI adjustment	275.00	307.50	334.70
4.	RI Adjustment at 8% (line 3 x .08)	22.00	24.60	26.78
5.	Trend Factor for Operating Component	11%	8%	7%
6.	Trended Operating Component (line 1 x line 5 + 100%)	277.50	299.70	320.68
7.	Prospective Rate (line 2 + line 4 + line 6)	$324.50	$354.30	$382.46

(3) Beginning July 1, 1987, the resident and intern cost adjustment will be paid on a quarterly basis established in June of each year. The quarterly payment will be prospective based on the RI rate established on the most recent cost report multiplied by the actual number of Medicaid days of the prior year established from paid claims from June - May fiscal year plus expected improvement based uopn a historical basis for the upcoming fiscal year July - June.

Beginning January 1, 1988, the resident and intern cost adjustment will be paid on a monthly basis established in June of each year. The monthly payment will be prospective based on the RI rate established on the most recent cost report multiplied by the actual number of Medicaid days of the prior year established from paid claims from June - May fiscal year plus expected improvement based upon a historical basis for the upcoming fiscal year July - June.

Based on example (2) above:

Days for June 86 - May 87.	4,000 days
Expected improvement. (for example increase in day limit)	100 days

Resident and intern payment 7/1/87 thru 6/30/88
4100 X $22 = $90,200

H. Medicaid Disproportionate Share Adjustment (MDSA) effective July 1, 1988

(1) Acute care hospitals having over 3,000 inpatient days attributable to patients determined eligible for Medicaid by the State of Tennessee or a utilization ratio of 14% or one standard deviation above the mean utilization ratio for all hospitals, whichever is lower, will be provided a payment incentive. The MDSA shall not be subject to trending. The MDSA will be the higher of (a) or (b) but shall not exceed 34% and (a) - (b) or (b) - (c) shall not exceed 44%.

(a) The prospective rate will be adjusted upward by 6% for each 1% increment in the utilization rate above 14% or one standard deviation above the mean, whichever is lower.

(b) The prospective rate will be adjusted upward by 6% for each increment of 1,000 reimbursed inpatient reported Medicaid days over 3,000 and the prospective rate will be increased upward by 3% if total days exceed 3,650 but less than 4,000.

(c) The prospective rate will be adjusted upward by 10% if outpatient services and outpatient pharmacy services are provided to Medicaid and/or non-Medicaid recipients who receive indigent services from the hospital. The hospital must qualify under (a) or (b) in order to receive this adjustment.

Also, in order to receive adjustment (c), the provider must be able to document that the services rendered qualify as free client care, under generally accepted accounting principles which are applicable to hospitals, and this does not include bad debt.

(d) No total payment of the disproportionate share adjustment will exceed 80% inpatient charity care plus 80% of inpatient bad debt. All inpatient charity care and inpatient bad debt will be determined by the latest industry complete Hospital Joint Annual Report as submitted to the State Center of Health Statistics.

(e) No disproportionate share payment will be made to hospitals that do not have at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under the State Medicaid Plan. The only exception will be made to hospitals which provide services to inpatients that are predominantly individuals under 18 years of age or who did not offer non-emergency obstetric services as of December 21, 1987.